Care Quality Commission

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Natural Smiles Leicester

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection on 9 January 2017 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

Natural Smiles is a dental practice providing private care for adults and children. Some treatment is provided under a fee per item basis and some under a dental insurance plan. The practice is situated in a converted modern property with all patient facilities on the ground floor.

The practice has two dental treatment rooms. There is also a reception and waiting area and other rooms used by the practice for office facilities and storage. The practice is open from 10.00am to 8.00pm on Mondays, 9.00am to 5.00pm on Tuesdays, 9.00am to 6.30pm on Wednesdays, 9.00am to 5.30pm on Thursdays and 9.00am to 5.00pm on Fridays.

The practice has one full time associate dentist and the principal dentist worked at the practice on a part-time basis. They are supported by two full time dental nurses, one of whom was also a treatment co-ordinator, a part time dental nurse, a practice manager and a dedicated full time receptionist.

The practice is able to provide general dental services including endodontic (root canal) treatment, short term orthodontic treatment, implants and cosmetic dentistry. The practice also provides the option of treatment under conscious sedation and the expected arrangements are in place to do this safely. Conscious sedation is the use of medicines to reduce alertness and help the patient relax but still be able to hear and respond to the dentist if necessary, while treatment is carried out.

Summary of findings

The associate dentist is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

Before the inspection we sent Care Quality Commission comment cards to the practice for patients to complete to tell us about their experience. We also spoke with patients on the day of our inspection. We received feedback from 22 patients. All the feedback was positive with patients commenting favourably on the quality and personalisation of care and service they received, the professional and helpful nature of staff and the cleanliness of the practice.

Our key findings were:

- Staff reported incidents which were investigated, and learning implemented to improve safety.
- The practice was visibly clean and well maintained but we found that not all infection control procedures were not in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health. For example a lack of airflow in the decontamination room and the ultrasonic bath being overloaded.
- The practice had medicines and equipment for use in a medical emergency which were in accordance with national guidelines with the exception that glucagon was stored in an unmonitored fridge. We were advised following our inspection that this had been rectified.
- Staff had received training appropriate to their roles and were supported in their continued professional development (CPD).
- Patients commented that they were very pleased with the care they received and that staff were helpful, kind and courteous. They also commented that they were always able to get appointments in a timely way, including in an emergency.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Arrangements for the provision of treatment under conscious sedation were in line with published guidance.
- Governance arrangements were in place for the smooth running of the service. However we found that some policies required dating or a review date included.

There were areas where the provider could make improvements and should:

- Review the practice's arrangements for receiving and responding to patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies such as, Public Health England (PHE).
- Review the practice's infection control procedures and protocols giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum

01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance.

- Review the practice's audit protocols to ensure they are carried out at appropriate intervals and check all audits have documented learning points and the resulting improvements can be demonstrated.
- Review governance arrangements, including acting on recommendations of the fire risk assessment, ensuring policies are dated and reviewed and ensuring staff performance appraisals take place regularly.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

No action

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice had a system in place to identify, investigate and learn from significant events.

There were sufficient numbers of suitably qualified staff working at the practice.

Staff had received safeguarding training and were aware of their responsibilities regarding safeguarding children and vulnerable adults. However some guidance was incorrect.

Infection control procedures were not always in line with the requirements of the 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health.

The practice had medicines and equipment for use in a medical emergency which were in accordance with national guidelines with the exception that glucagon was stored in an unmonitored fridge. We were advised following our inspection that this had been addressed.

Arrangements for the provision of treatment under conscious sedation were in line with published guidance.

Use of X-rays on the premises was in line with the Regulations. However on the day of our inspection the evidence that annual mechanical and electrical tests had been done was not available. We were told following our inspection that these had been booked.

Are services effective?

No action

We found that this practice was providing effective care in accordance with the relevant regulations.

The dental care provided was evidence based and focussed on the needs of the patients. The clinicians used current national professional guidance including that from the National Institute for Health and Care Excellence (NICE) to guide their practice.

Staff demonstrated a commitment to oral health promotion.

The staff received ongoing professional training and development appropriate to their roles and learning needs.

Clinical staff were registered with the General Dental Council (GDC) and were meeting the requirements of their professional registration

The practice had a process in place to make referrals to other dental professionals when appropriate to do so.

Are services caring?

No action

We found that this practice was providing caring services in accordance with the relevant regulations.

We received feedback from 22 patients and these provided an overwhelmingly positive view of the service the practice provided. Comments reflected that patients were very satisfied with the

Summary of findings

care they received and commented on the quality and personalisation of care and service they received, the professional and helpful nature of staff and the cleanliness of the practice. Patients told us treatment options were explained to them and they were involved in decisions about their treatment.

We observed that patients were treated with dignity and respect and the confidentiality of patients' private information was maintained.

Are services responsive to people's needs?

No action 

We found that this practice was providing responsive care in accordance with the relevant regulations.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Routine dental appointments were readily available, as were urgent on the day appointments and patients told us it was easy to get an appointment with the practice. Information was readily available for patients in the practice and on their website.

All patient services were on the ground floor. Treatment rooms were fully wheelchair accessible and there was a wheelchair accessible toilet.

Information about how to complain was available to patients. The practice had not received any complaints since they opened in 2015.

The practice had access to a translation service but did not have a hearing loop to support patients with a hearing impairment. However they purchased one on the day of our inspection.

Are services well-led?

No action 

We found that this practice was providing well-led care in accordance with the relevant regulations.

Staff told us that they felt well supported and enjoyed their work.

Although staff had not received regular appraisal of their performance we saw that these were scheduled. There were regular practice meetings.

The practice had policies and protocols in place to assist in the smooth running of the practice.

There was an open culture within the practice and staff were well supported and able to raise any concerns within the practice.

Feedback was obtained from patients and we saw evidence that this was discussed and were told it would be acted upon to make changes to the service provided if appropriate.

Natural Smiles Leicester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008

We carried out an announced, comprehensive inspection on 9 January 2017. The inspection was led by a CQC inspector who was supported by a specialist dental adviser and a second CQC inspector.

We reviewed information we held about the practice prior to our inspection.

During the inspection we spoke with the practice manager, two dentists, dental nurses, the receptionist and the area manager.

To assess the quality of care provided we looked at practice policies and protocols and other records relating to the management of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

We spoke with the dentists who were aware of and understood the Reporting of Injuries, Disease and Dangerous Occurrences Regulations 2013 (RIDDOR). Accident forms were available which aided staff to consider when a report would be necessary.

The practice had systems and processes to report, investigate and learn from significant events and near misses. There was a significant event policy dated July 2016 and a recording form available. Events were recorded within the practice and we looked at the three significant events which had been reported and saw that changes had been implemented as a result of these. For example, Records we looked at demonstrated that events had been reviewed and discussed at the next practice meeting in order to share any learning. For example, as a result of one significant event changes had been made to a protocol and training implemented.

The practice manager told us that national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) that affected the dental profession were sent to the practice email address. They told us that this was checked regularly and had been acted upon. There was no log of safety alerts received available to identify what actions had been taken and we found that the practice manager was not aware of an alert published on 13 October 2016 by the MHRA relating to a faulty defibrillator. The practice manager told us they would review the system for dealing with safety alerts to ensure all alerts were acted upon.

Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The practice had a duty of candour policy and staff we spoke with showed an awareness of this and told us they were encouraged to be open and honest if anything was to go wrong.

Reliable safety systems and processes (including safeguarding)

The practice had policies in place for safeguarding children and vulnerable adults which had been reviewed in April 2016. The principal dentist was named as the safeguarding lead for the practice. However we found that some of the contact details within the policy related to a different area. The practice manager told us they would update the policy.

We saw evidence that all staff had received safeguarding training to level two which with the exception of the dentists was the appropriate level for their role

The practice had an up to date employers' liability insurance certificate. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969. This was due for renewal in March 2017.

We spoke with the dentists who told us that without exception they used rubber dams when providing root canal treatment to patients. This was in line with guidance from the British Endodontic Society. A rubber dam is a thin, square sheet, usually latex rubber, used in dentistry to isolate the operative site from the rest of the mouth and protect the airway. Rubber dams should be used when endodontic treatment (treatment involving the root canal of the tooth) is being provided.

We spoke with staff about the procedures to reduce the risk of sharps injury in the practice. The practice had a comprehensive sharps injury protocol which staff were conversant with. A sharps risk assessment had been undertaken and dental nurses did not handle sharps. Although some traditional sharps were still in use the practice were moving towards using 'safer sharps' in line with the requirements of the Health and Safety (Sharp Instruments in Healthcare) 2013 regulation.

The practice provided conscious sedation and we found that they were meeting the standards set out in the guidelines published by the Standing Dental Advisory Committee – 'Conscious Sedation in the Provision of Dental Care. Report of an Expert Group on Sedation for Dentistry' commissioned by the Department of Health in 2003. Conscious sedation is the use of medicines to reduce alertness and help the patient relax but still be able to hear and respond to the dentist if necessary, while treatment is carried out.

Are services safe?

Medical emergencies

The dental practice had medicines and equipment in place to manage medical emergencies. Staff were aware of their location and how to access them. Emergency medicines were available in line with the recommendations of the British National Formulary.

With the exception of portable suction, the equipment available for use in a medical emergency was in line with the recommendations of the Resuscitation Council UK, and included an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. We were informed following our inspection that portable suction equipment had been purchased.

There was a first aid kit available which was in date. There were trained first aiders within the practice.

There was a system in place to ensure that all medicines and equipment were checked on a regular basis to confirm they were in date and serviceable should they be required. Records we saw showed that the emergency medicines and equipment were checked on a weekly basis. These checks ensured the oxygen cylinder was sufficiently full, the AED was fully charged and the emergency medicines were in date. We saw that the oxygen cylinder was serviced on an annual basis.

We found that the glucagon which the practice held for emergencies was being stored in the refrigerator. However the temperature of the refrigerator was not being monitored to ensure a temperature of 2-8o was being maintained. Glucagon can be stored outside of a refrigerator but with a shortened expiry date of 18 months. Following our inspection the practice manager provided evidence that new stock had been ordered and the expiry date shortened.

Staff based at the practice had completed practical training in emergency resuscitation and basic life support in February 2016 and the practice had undertaken training in emergency scenario simulation in October 2015 but the scenario training had not been maintained. The practice manager told us following our inspection that going forward this would be carried out as part of the monthly staff meetings.

Staff recruitment

The practice had a recruitment policy which had been reviewed in June 2016. We reviewed three staff recruitment files which were well organised and saw evidence that appropriate recruitment checks were present, such as qualifications, photographic proof of identification and registration with the appropriate professional body. The practice manager told us that not all staff had received checks through the Disclosure and Barring Service (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However we saw evidence that checks had now been applied for relating to all staff.

Monitoring health & safety and responding to risks

The practice had systems to identify and mitigate risks to staff, patients and visitors to the practice.

The practice had a health and safety policy which was dated April 2016 and was accessible for all staff to reference in a folder. A health and safety risk assessment had been carried out in April 2016 and included risk assessments for clinical waste disposal, radiation and environmental hazards.

There was no fire policy available but we were told that a fire risk assessment had been carried out in January 2017. The report had not been received by the practice at the time of our inspection but following our inspection they forwarded it to us. It made a number of recommendations and the practice sent us a copy of their action plan in respect of this which indicated the recommendations would be completed by the end of February 2017.

Staff had received fire safety training and there were trained fire marshals. We saw that a fire drill had last been undertaken in April 2016. Checks of the fire alarm had been carried out on a weekly basis. However other fire safety equipment such as fire extinguishers had not been regularly checked. We saw that the emergency lighting had been checked on a monthly basis. The practice manager told us that in future all fire safety equipment would be checked.

There were arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations.

Are services safe?

There was a file of information pertaining to the hazardous substances used in the practice with safety data sheets for each product which detailed actions required to minimise risk to patients, staff and visitors.

On the day of our inspection there was no business continuity plan available for major incidents such as fire, loss of computer system or power failure. However following our inspection this was forwarded to us and we saw that it gave details of alternative premises to be used if necessary. The plan also contained details of contractors who might be required in these instances.

Infection control

The 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' published by the Department of Health sets out in detail the processes and practices essential to prevent the transmission of infections. We discussed the practice's processes for cleaning, sterilising and storing dental instruments and reviewed their policies and procedures.

The practice had infection control policies which were not dated. These gave guidance on areas which included the decontamination of instruments and equipment, spillage procedures, waste disposal and environmental cleaning of the premises.

The practice did not have an annual infection prevention control statement in line with the Department of Health code of practice and the principal dentist was not aware of the requirement for this. Following our inspection an annual infection prevention control statement was provided.

The decontamination process was performed in a dedicated decontamination room and we discussed the process with a dental nurse.

Instruments were cleaned manually before being further cleaned in an ultrasonic bath (this is designed to clean dental instruments by passing ultrasonic waves through a liquid). Instruments were then inspected under an illuminated magnifier before being sterilised in an autoclave (a device used to sterilise medical and dental instruments). During the demonstration of the decontamination process we noted that the ultrasonic bath was overloaded. We pointed this out to the provider who assured us this would be rectified.

The dental nurse demonstrated that systems were in place to ensure that the autoclaves used in the decontamination process were working effectively.

We saw that the required personal protective equipment was available for staff throughout the decontamination process.

We observed that the sinks used in the decontamination room required the overflows blanking and plugs removing. We received evidence following our inspection that this had been initiated. We also saw that both sinks in the room were used with cleaning solution rather than one of the sinks being used for rinsing. Additionally there was no airflow in operation in the decontamination room in order to improve the segregation of clean to contaminated activities.

The segregation and storage of clinical waste was generally in line with current guidelines laid down by the Department of Health. We observed that sharps containers, clinical waste bags and general waste were used and stored in accordance with current guidelines. The practice used an approved contractor to remove clinical waste from the practice. We saw the appropriate waste consignment notices.

Practice staff told us how the dental water lines were maintained to prevent the growth and spread of Legionella bacteria (legionella is a term for particular bacteria which can contaminate water systems in buildings) they described the method they used which was in line with current HTM 01 05 guidelines. There was a self-flushing system in operation which self-disinfected during surgeries. We saw a Legionella risk assessment which had been carried out at the practice by an external company in April 2015. There were a number of control measures recommended as a result of the risk assessment. It was not clear on the day of our inspection if all the control measures had been implemented but following our inspection evidence was provided which confirmed they had been.

We saw evidence that clinical staff had been vaccinated against Hepatitis B (a virus that is carried in the blood and may be passed from person to person by blood on blood contact).

We saw that the dental treatment rooms, waiting area, reception and toilets were clean, tidy and clutter free. Hand washing facilities were available including liquid soap and

paper towels. However hand cream was not available. Hand washing protocols were displayed appropriately in various areas of the practice. Each treatment room had the appropriate routine personal protective equipment available for staff use.

The practice contracted a cleaning company to carry out environmental cleaning tasks. This was carried out on a regular basis. We saw there were records of cleaning in line with the schedule and the external company used colour coded cleaning equipment in line with national guidelines.

Equipment and medicines

Staff told us they had enough equipment to carry out their job and there were adequate numbers of instruments available for each clinical session to take account of decontamination procedures. We saw evidence that some equipment checks had been regularly carried out in line with the manufacturer's recommendations. The practices' X-ray machines had not all been serviced as specified under current national regulations at the time of our inspection but this was booked following our inspection. Portable appliance testing (PAT) had been carried out in January 2017. A new compressor had been installed in April 2015 and this was serviced in January 2017.

The autoclave had also been serviced in January 2017.

Dentists used the British National Formulary and told us they would report any patient adverse reactions to medicines through the MHRA. We found that there was no overview of antibiotic prescribing. This is a requirement of the provider under Criterion 3 of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections which was updated in 2015.

Radiography (X-rays)

The practice demonstrated compliance with the Ionising Radiation Regulations (IRR) 1999, and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000.

The practice used two intra-oral X-ray machines which can take an image of one or a few teeth at a time. They also used an Orthopantomogram machine which can take a panoramic scanning dental X-ray of the upper and lower jaw. The practice displayed the 'local rules' of the X-ray machine in the room where each X ray machine was located but these were not unit specific.

The practice used exclusively digital X-rays, which were available to view almost instantaneously, as well as delivering a lower effective dose of radiation to the patient.

The practice kept a radiation protection file which contained the names of the Radiation

Protection Advisor and the Radiation Protection Supervisor. On the day of our inspection the list of X-ray equipment was not available but was provided following our inspection.

We saw that all dental professionals were up to date with radiation training as specified by the General Dental Council.

The justification for taking an X-ray as well as the quality grade, and a report on the findings of that X-ray were documented in the dental care record for patients as recommended by the Faculty of General Dental Practice.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

We spoke with the two dentists who demonstrated their awareness of National Institute for Health and Clinical Excellence (NICE) and the Faculty of General Dental Practice (FGDP) guidelines and we saw that these were being followed as well as other guidelines such as those of the Association of Dental Implantology and The British Society of Periodontology.

Discussions with the dentists and records we reviewed demonstrated that consultations, assessments and treatment were in line with these recognised professional guidelines. The dentists described to us and we looked at records which confirmed how they carried out their assessment of patients for routine care. We saw evidence of an oral health assessment at each examination and risk assessments covering the condition of a patient's teeth, gums and soft tissues and the signs of mouth cancer, in the sample of dental care records we reviewed. Patient medical history was also checked at each visit.

We saw that records also included details of the condition of the gums using the basic periodontal examination (BPE) scores and soft tissues lining the mouth. (The BPE tool is a simple and rapid screening tool used by dentists to indicate the level of treatment need in relation to a patient's gums). Following the clinical assessment records reflected discussions with the patient which included good detail of the treatment options and outcomes of these discussions.

The decision to take X-rays was guided by clinical need, and in line with the Faculty of General Dental Practitioners directive. Records we looked at showed that radiographs had been recorded including their justification and grading.

Health promotion & prevention

Despite being a private practice, dentists we spoke with were aware of and applying guidelines issued by the Department of Health publication 'Delivering better oral health: an evidence-based toolkit for prevention'. This is an evidence-based toolkit used by dental teams for the prevention of dental disease in a primary and secondary care setting. The dentists told us they regularly provided smoking and alcohol cessation advice to patients. Staff were aware of local smoking cessation services and there was information available for patients wanting to give up smoking.

The practice sold a range of dental hygiene products to maintain healthy teeth and gums such as toothbrushes and mouthwashes.

Staffing

The practice was staffed by one full time and one part time dentist. They were supported by two full time dental nurses; one of whom was also a treatment co-ordinator, a part time dental nurse, a practice manager and a receptionist.

Prior to our visit we checked the registrations of the dental care professionals and found that they all had up to date registration with the General Dental Council (GDC). We asked to see evidence of indemnity cover for relevant staff (insurance professionals are required to have in place to cover their working practice) and saw that cover was in place for all dental professionals.

We found that staff had good access to on-going training to support their skill level and they were encouraged to maintain the continuous professional development (CPD) required for registration with the General Dental Council (GDC). The GDC is the statutory body responsible for regulating dentists, dental therapists, dental hygienists, dental nurses, clinical dental technicians, orthodontic therapists and dental technicians. We found that training needs of staff were monitored and clinical staff were up to date with their recommended CPD as detailed by the GDC including medical emergencies, infection control and safeguarding.

Records at the practice showed that staff appraisals were overdue but we saw that these were scheduled to be undertaken later in the month. We saw evidence of an induction programme for new staff.

Working with other services

The dentists and practice manager explained how they worked with other services. The dentists referred patients to a range of specialists in primary and secondary services for more complex endodontic, periodontic and orthodontic treatments, and minor oral surgery when the treatment

Are services effective?

(for example, treatment is effective)

required could not be provided in the practice. Referrals could be tracked on the software system in use in the practice. Referrals for suspected cancer were fast tracked and made by phone followed by a letter.

Consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Staff we spoke with had undertaken training in the MCA and its relevance when dealing with patients who might not have capacity to make decisions for themselves and when a best interest decision may be required. They also demonstrated their understanding regarding Gillick competence which relates to children under the age of 16 being able to consent to treatment if they are deemed competent.

We spoke with two of the dentists and found they had a clear understanding of consent issues and that they described how they explained and discussed different treatment options with patients, outlining the pros and cons and consequences of not carrying out treatment. This was clearly documented in the sample of dental care records we reviewed. We also saw that patients were given written treatment plans and signed a consent form and for more complex treatments the treatment planning was multi-stage with written plans and costs at each stage. Patients were also given time to reconsider the chosen treatment plan. Treatment co-ordinators were available to further discuss patient's options and plans following their consultation with the dentists.

Are services caring?

Our findings

Respect, dignity, compassion & empathy
Before our inspection, Care Quality Commission (CQC) comment cards were left at the practice to enable patients to tell us about their experience of the practice. We also spoke with patients on the day of our inspection. We received feedback from 22 patients. All the feedback was positive with patients commenting favourably on the quality and personalisation of care and service they received and the professional, understanding and helpful nature of staff.

The confidentiality of patients' private information was maintained as patient care records were computerised and practice computer screens were not visible at reception which ensured patients' confidential information could not be seen.

Treatment room doors were closed when patients were with dentists and conversations between patients and dentists could not be overheard from outside the rooms.

Involvement in decisions about care and treatment
From our discussions with dentists, extracts of dental care records we were shown and feedback from patients it was apparent that patients were given clear treatment plans which contained details of treatment options and the associated cost.

A price list for treatments was displayed in the reception area and was also available on the practice website.

Patients told us that they always felt listened to and plenty of time was taken to explain treatments to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

During our inspection we found that the practice had good facilities and was well equipped to treat patients and meet their needs.

We saw that a range of information was available in the waiting area. This included information about the services offered by the practice, health promotion, complaints information and the cost of treatments.

Patients commented that they were always able to get appointments easily and sufficient time was given for appointments to allow for assessment and discussion of their needs. There were also treatment coordinators to go through information and options with patients to make sure they had enough time and the answers to their questions to make treatment choices.

Staff said that when patients were in pain or where treatment was urgent the practice saw patients on the same day. Comments from patients confirmed how accommodating the practice were when their needs were considered more urgent.

Tackling inequity and promoting equality

Staff had undertaken equality and diversity training to increase their awareness of the need to treat all patients equally while recognising their individual needs. All services were on the ground floor of the premises and facilities were accessible to all patients, including those patients with limited mobility, as well as parents and carers using prams and pushchairs. There was also an accessible toilet suitable for wheelchair users.

The practice were able to access a translation service to support patients whose first language was not English if this was required. Practice staff also spoke a number of languages. The practice did not have a hearing loop in the reception area to assist patients with a hearing impairment. A hearing loop was purchased during our inspection to address this.

Access to the service

The practice was open from 10.00am to 8.00pm on Mondays, 9.00am to 5.00pm on Tuesdays, 9.00am to 6.30pm on Wednesdays, 9.00am to 5.30pm on Thursdays and 9.00am to 5.00pm on Fridays.

The practice was situated in a suburb of Leicester. Car parking was available with disabled car parking immediately outside the practice. The practice was also on a bus route.

In the case of an emergency when the practice was closed, patients were advised of contact details for the dentist on cover at that time through a recorded message on the telephone answering service. The practice website also gave details of what to do in an emergency.

The practice had a website and patients were able to access information or check opening times or treatment options on-line via this means.

The practice operated a reminder service for patients who had appointments with the dentists. Patients received an email reminder a week before their appointment which was followed by a reminder by text or telephone call depending on their preference, two days before their appointment.

Concerns & complaints

The practice had a complaints policy which was not dated but had been signed by all staff to indicate they had read and understood it. The policy explained how to complain and identified time scales for complaints to be responded to. Other agencies to contact if the complaint was not resolved to the patients satisfaction were identified within the policy.

Information about how to complain was available in the waiting room and on the practice website. The practice manager was the person responsible for dealing with complaints in the practice.

We found there had been no complaints since the practice opened in 2015.

Are services well-led?

Our findings

Governance arrangements
There was a governance framework in place which provided a staffing structure whereby staff were clear about their own roles and responsibilities.

Practice specific policies were available which had been signed by staff to indicate they had read and understood them. Some of these were undated or the date of review was not indicated. We looked at policies which included those which covered infection control, health and safety, complaints, consent, sedation and safeguarding children and vulnerable adults. We found that some of the contact information relating to safeguarding was incorrect.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency
The leadership team within the practice consisted of the associate dentist and the practice manager who also managed the provider's other practice in Corby, with support from the provider who was primarily based at the other practice. Staff told us they felt able to raise concerns within the practice and were listened to and supported if they did so. Staff we spoke with told us they were a close and effective team.

The practice was aware of the duty of candour and this was demonstrated in the records we reviewed relating to incidents.

We saw evidence of regular staff meetings which staff were encouraged to participate in fully. The meetings were minuted and available for staff unable to attend.

Learning and improvement
There was a programme of clinical audits in place in order to monitor quality and to make improvements. We saw that infection control audits had been carried out annually with the last one having been undertaken in April 2016. However these should be undertaken at six monthly intervals. The provider told us they would implement these at the required intervals and following our inspection provided evidence that a further audit had been undertaken with the practice achieving 99% compliance.

We also saw that an audit of clinical record keeping had taken place in April 2016 and was comprehensive. However this related to the associate dentist and there was no audit available relating to the principal dentist.

We saw there was a log of all X-rays taken but no audit of the quality and justification of radiography (X-rays) had been carried out. We raised this with the principal dentist and following our inspection they provided an appropriate audit which identified that no action was required as a result. Other audits that had been undertaken in 2016 included those relating to hand hygiene, antibiotic use, medical history, appointments and environmental cleaning.

Staff were supported in achieving the General Dental Council's requirements in continuing professional development (CPD). We saw evidence that clinical staff were up to date with the recommended CPD requirements of the GDC.

The practice ensured that all staff underwent regular training in cardio pulmonary resuscitation (CPR), infection control, safeguarding of children and vulnerable adults and dental radiography (X-rays). Staff development was by means of internal training, staff meetings and attendance on external courses.

Records at the practice showed that staff appraisals were overdue but we saw that these were scheduled to be undertaken later in the month.

Practice seeks and acts on feedback from its patients, the public and staff
The practice gained feedback from patients by different methods. There was a comments book at reception. We saw there were 55 comments recorded which were all positive. They had also undertaken regular surveys to gain patient feedback on areas such as staffing, value for money, waiting times and explanations of treatment. The results of the most recent survey were displayed in the waiting room and reflected that across these areas patients responded very positively.

We were told that patient feedback and survey results were discussed as a team at practice meetings. Patients were also able to leave feedback online through the practice website.

Are services well-led?

It was clear from the staff we spoke with and the minutes of practice meetings that staff were able and felt confident to raise issues for discussion formally or informally and were supported to do so.